

Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to Oklahoma Health Care Authority (OHCA) Health Policy Unit <http://www.okhca.org/proposed-rule-changes.aspx>

OHCA COMMENT DUE DATE: February 17, 2017

The proposed policy is a Permanent Rule. The proposed policy was presented at the January 3, 2017 Tribal Consultation and is scheduled to be presented to the Medical Advisory Committee on March 09, 2017 and the Board of Directors on March 23, 2017.

Reference: APA WF # 16-35

SUMMARY:

Outpatient behavioral health policy revisions - Proposed policy revisions remove outdated references to Axis diagnosis and add new language to align with changes to the Diagnostic and Statistical Manual of Mental Disorders (DSM). Additional revisions clarify clinical outpatient behavioral health agency provider documentation requirements for changes to the service plan prior to the scheduled six month review/update. Rules are also revised to clarify that behavioral health case management is not reimbursable for members who are enrolled in a Health Home. Additionally, rules are revised to clarify that, unless otherwise specified in rule, reimbursement is not allowed for outpatient behavioral health services provided to members who are considered to be in "inpatient status". Further, rules are amended to reduce the number of SoonerCare compensable service plan updates to two in one year. As a result, outpatient behavioral health agencies will receive reimbursement for one initial comprehensive treatment plan and one update thereto bi-annually.

LEGAL AUTHORITY

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 441.18; 42 U.S.C. 1396w-4

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Federal and State Policy

FROM: Traylor Rains-Sims
Oklahoma Department of Mental Health & Substance Abuse

Services

SUBJECT: Rule Impact Statement
APA WF # 16-35

A. Brief description of the purpose of the rule:

The proposed policy revisions reduce the number of SoonerCare compensable service plan updates to two in one year. Outpatient behavioral health agencies will now be reimbursed for one initial comprehensive treatment plan and one update thereto bi-annually. **The aforementioned changes were approved during promulgation of the emergency rule.**

The following are proposed changes not previously reviewed. The proposed policy revisions remove outdated references to Axis diagnosis to align with changes to the Diagnostic and Statistical Manual of Mental Disorders (DSM). In addition, revisions clarify clinical outpatient behavioral health agency provider documentation requirements for changes to the service plan prior to the scheduled six month review or update.

Rules are also revised to clarify that behavioral health case management is not reimbursable for members who are enrolled in a Health Home.

Rules are revised to clarify that, unless otherwise specified in rule, reimbursement is not allowed for outpatient behavioral health services provided to members who are considered to be in "inpatient status".

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

No particular class of persons will be affected by the proposed rule. The change is being made to align policy with current auditing practice. No cost impacts have been received by the agency from any private or public entity.

C. A description of the classes of persons who will benefit from the proposed rule:

Contracted outpatient behavioral health providers may benefit from the rule, as it may allow providers to have a clear understanding of documentation requirements for when changes need to be made to the service plan prior to the scheduled six month review/update. The change will also assist providers with current auditing practices preventing the risk of recoupment.

- D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no economic impact and there are no fee changes associated with the rule change for the above classes of persons or any political subdivision.

- E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated effect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

There are no probable costs or benefits to the agency nor to any other agency for the implementation and enforcement of the proposed rule.

- F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

The proposed rule will not have an economic impact on any political subdivision nor will it require the cooperation of any political subdivision in implementing or enforcing the rule.

- G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

The proposed rule will not have an adverse impact on small business.

- H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

Throughout the year Agency staff gather relevant information through stakeholder involvement and public forums in order to communicate the planned actions of the Agency concerning rulemaking, as well as other issues. While it is difficult to balance the needs of SoonerCare members with those of the various providers, the Agency proposes rules with each of these issues and interests considered.

- I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is

designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should have no adverse effect on the public health, safety, and environment.

- J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

The Agency has determined that the proposed rules will have no detrimental effect on the public health, safety and environment if they are not implemented.

- K. The date the rule impact statement was prepared and if modified, the date modified:

The rule impact statement was prepared December 2, 2016.

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-11. Psychiatric services

(a) Payment is made for procedure codes listed in the Psychiatry section of the most recent edition of the American Medical Association Current Procedural Terminology codebook. The codes in this service range are accepted services within the SoonerCare program for children and adults with the following exceptions:

(1) Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes.

(2) Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist the patient.

(3) Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other physicians, agencies, or insurance carriers.

(4) Unlisted psychiatric service or procedure.

(b) All services must be medically necessary and appropriate and include a Diagnostic and Statistical Manual (DSM) multi-axial diagnosis completed for all five axes at least one Diagnostic and Statistical Manual (DSM) diagnosis from the most recent version of the DSM.

(c) Services in the psychiatry section of the CPT manual must be provided by a board eligible or board certified psychiatrist or a physician, physician assistant, or nurse practitioner with additional training that demonstrates the knowledge to conduct the service performed.

(d) Psychiatric services performed via telemedicine are subject to the requirements found in OAC 317:30-3-27.

PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

317:30-5-241. Covered Services

(a) Outpatient behavioral health services are covered for adults and children as set forth in this Section when provided in accordance with a documented individualized service plan, developed to treat the identified behavioral health and/or substance use disorder(s), unless specified otherwise.

(b) All services are to be for the goal of improvement of functioning, independence, or well-being of the member. The services and service plans are to be recovery focused, trauma and co-occurring specific. The member must be able to actively participate in the treatment. Active participation means that the member must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment.

(c) In order to be reimbursed for services, providers must submit a completed Customer Data Core (CDC) to OHCA or its designated agent. The CDC must be reviewed, updated and resubmitted by the provider every six months. Reimbursement is made only for services provided while a current CDC is on file with OHCA or its designated agent. For further information and instructions regarding the CDC, refer to the ~~Behavioral Health Provider Manual~~ Prior Authorization Manual.

(d) All outpatient BH services must be provided following established medical necessity criteria. Some outpatient behavioral health services may require authorization. For information regarding services requiring authorization and the process for obtaining them, refer to the ~~Behavioral Health Provider Manual~~ Prior Authorization Manual. Authorization of services is not a guarantee of payment. The provider is responsible for ensuring that the eligibility, medical necessity, procedural, coding, claims submission, and all other state and federal requirements are met. OHCA does retain the final administrative review over both authorization and review of services as required by 42 CFR 431.10.

(e) Services to nursing facility residents. Reimbursement is not allowed for outpatient behavioral health services provided to members residing in a nursing facility. Provision of these services is the responsibility of the nursing facility and reimbursement is included within the rate paid to the nursing facility for the member's care.

~~(f) In addition to individual service limitations, reimbursement for outpatient behavioral health services is limited to 35 hours~~

~~per rendering provider per week. Service hours will be calculated using a rolling four week average. Services not included in this limitation are:~~

~~(f) Services to members during an inpatient stay. Unless otherwise specified in rules, reimbursement is not allowed for outpatient behavioral health services provided to members who are considered to be in "inpatient status" as defined in OAC 317:30-5-41.~~

~~(g) In addition to individual service limitations, reimbursement for outpatient behavioral health services is limited to 35 hours per rendering provider per week. Service hours will be calculated using a rolling four week average. Services not included in this limitation are:~~

- ~~(1) Assessments;~~
- ~~(2) Testing;~~
- ~~(3) Service plan development; and~~
- ~~(4) Crisis intervention services.~~

317:30-5-241.1. Screening, assessment and service plan

All providers must comply with the requirements as set forth in this Section.

(1) Screening.

(A) **Definition.** Screening is for the purpose of determining whether the member meets basic medical necessity and need for further BH assessment and possible treatment services.

(B) **Qualified professional.** Screenings can be performed by any credentialed staff members as listed under OAC 317:30-5-240.3.

(C) **Target population and limitations.** Screening is compensable on behalf of a member who is seeking services for the first time from the contracted agency. This service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in service of more than six (6) months. To qualify for reimbursement, the screening tools used must be ~~evidence based~~evidence-based or otherwise approved by OHCA and ODMHSAS and appropriate for the age and/or developmental stage of the member.

(2) Assessment.

(A) **Definition.** Gathering and assessment of historical and current bio-psycho-social information which includes face-to-face contact with the person and/or the person's family or other informants, ~~or group of persons~~person(s) resulting in a written summary report, diagnosis and recommendations. All agencies must assess the medical necessity of each individual to determine the appropriate level of care.

(B) **Qualified practitioners.** This service is performed by an LBHP or Licensure Candidate.

(C) **Target population and limitations.** The Behavioral Health Assessment ~~by a Non-Physician, moderate complexity,~~ is compensable on behalf of a member who is seeking services for

the first time from the contracted agency. This service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in service of more than six (6) months and it has been more than one (1) year since the previous assessment.

(D) **Documentation requirements.** The assessment must include all elements and tools required by the OHCA. In the case of children under the age of ~~18~~eighteen (18), it is performed with the direct, active face-to-face participation of the parent or guardian. The child's level of participation is based on age, developmental and clinical appropriateness. The assessment must include at least one DSM diagnosis from the most recent DSM edition. The information in the assessment must contain but is not limited to the following:

- (i) Behavioral, including substance use, abuse, and dependence;
- (ii) Emotional, including issues related to past or current trauma;
- (iii) Physical;
- (iv) Social and recreational;
- (v) Vocational;
- (vi) Date of the assessment sessions as well as start and stop times;
- (vii) Signature of parent or guardian participating in face-to-face assessment. ~~Signature~~Signatures are required for members over the age of ~~14~~fourteen (14); and
- (viii) Signature and credentials of the practitioner who performed the face-to-face behavioral assessment

(3) Behavioral Health Services Plan Development.

(A) **Definition.** The Behavioral Health Service Plan is developed based on information obtained in the assessment and includes the evaluation of all pertinent information by the practitioners and the member. ~~It includes,~~ including a discharge plan. It is a process whereby an individualized plan is developed that addresses the member's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. Behavioral Health Service Plan Development is performed with the direct active participation of the member and a member support person or advocate if requested by the member. In the case of children under the age of ~~18~~eighteen (18), it is performed with the participation of the parent or guardian and the child as age and developmentally appropriate, and must address school and educational concerns and assisting the family in caring for the child in the least restrictive

level of care. For adults, it is focused on recovery and achieving maximum community interaction and involvement including goals for employment, independent living, volunteer work, or training. A Service Plan Development, Low Complexity is required every ~~6~~six (6) months and must include an update to the bio-psychosocial assessment and re-evaluation of diagnosis.

(B) **Qualified practitioners.** This service is performed by an LBHP or Licensure Candidate.

(C) **Time requirements.** Service Plan updates must be conducted face-to-face and are required every six (6) months during active treatment. ~~Updates~~However, updates can be conducted whenever it is clinically needed as determined by the qualified practitioner and member, but are only compensable twice in one year.

(D) **Documentation requirements.** Comprehensive and integrated service plan content must address the following:

- (i) member strengths, needs, abilities, and preferences~~(SNAP)~~ (SNAP);
- (ii) identified presenting challenges, problems, needs and diagnosis;
- (iii) specific goals for the member;
- (iv) objectives that are specific, attainable, realistic, and time-limited;
- (v) each type of service and estimated frequency to be received;
- (vi) the practitioner(s) name and credentials that will be providing and responsible for each service;
- (vii) any needed referrals for service;
- (viii) specific discharge criteria;
- (ix) description of the member's involvement in, and responses to, the service plan, and his/her signature and date;
- (x) service plans are not valid until all signatures are present (signatures are required from the member, if 14 or over), the parent/guardian (if younger than 18 or otherwise applicable), and the primary LBHP or Licensure Candidate; and
- (xi) all changes in a service plan must be documented in either a scheduled six (6) month service plan update (low complexity) or within the existing service plan through an amendment until time for the update (low complexity). Any changes to the existing service plan must, prior to implementation, be signed and dated by the member (if 14 or over), the parent/guardian (if younger than 18 or otherwise applicable), and the lead LBHP or Licensure Candidate.

~~(xii) Updates to goals, objectives, service provider, services, and service frequency, must be documented within the service plan until the six month review/update is due.~~
~~(xiii) Service plan updates must address the following:~~
~~(I) update to the bio-psychosocial assessment, re-evaluation of diagnosis service plan goals and/ or objectives;~~
~~(II) progress, or lack of, on previous service plan goals and/or objectives;~~
~~(III) a statement documenting a review of the current service plan and an explanation if no changes are to be made to the service plan;~~
~~(IV) change in goals and/or objectives (including target dates) based upon member's progress or identification of new need, challenges and problems;~~
~~(V) change in frequency and/or type of services provided;~~
~~(VI) change in practitioner(s) who will be responsible for providing services on the plan;~~
~~(VII) change in discharge criteria;~~
~~(VIII) description of the member's involvement in, and responses to, the service plan, and his/her signature and date; and~~
~~(IX) service plans are not valid until all signatures are present. The required signatures are: from the member (if 14 or over), the parent/guardian (if younger than 18 or otherwise applicable), and the primary LBHP or Licensure Candidate.~~

(xii) Amendment of an existing service plan to revise or add goals, objectives, service provider, service type, and service frequency, may be completed prior to the scheduled six (6) month review/update. A plan amendment must be documented through an addendum to the service plan, dated and signed prior to the implementation, by the member (if 14 or over), the parent/guardian (if younger than 18 or otherwise applicable), and the lead LBHP or Licensure Candidate.

(xiii) Behavioral health service plan development, low complexity, must address the following:

- (I) update to the bio-psychosocial assessment, re-evaluation of diagnosis service plan goals and/ or objectives;
- (II) progress, or lack of, on previous service plan goals and/or objectives;
- (III) a statement documenting a review of the current service plan and an explanation if no changes are to be made to the service plan;
- (IV) change in goals and/or objectives (including target dates) based upon member's progress or identification of new need, challenges and problems;

(V) change in frequency and/or type of services provided;
(VI) change in practitioner(s) who will be responsible for providing services on the plan;
(VII) change in discharge criteria;
(VIII) description of the member's involvement in, and responses to, the service plan, and his/her signature and date; and
(IX) service plan updates (low complexity) are not valid until all signatures are present. The required signatures are: from the member (if 14 or over), the parent/guardian (if younger than 18 or otherwise applicable), and the primary LBHP or Licensure Candidate.

(E) Service limitations:

(i) Behavioral Health Service Plan Development, Moderate ~~complexity~~ Complexity (i.e., pre-admission procedure code group) ~~are~~ is limited to ~~one~~ (1) per member, per provider, unless more than ~~a one~~ (1) year has passed between services, ~~then another one in which case, one can be requested and may be performed, if authorized by OHCA or its designated agent.~~

(ii) Behavioral Health Service Plan Development, Low Complexity: Service Plan updates are required every six (6) months during active treatment. Updates, however, can be conducted whenever clinically needed as determined by the provider and member, but are only reimbursable twice in one (1) year. The date of service is when the service plan is complete and the date the last required signature is obtained. Services should always be age, developmentally, and clinically appropriate.

(4) Assessment/Evaluation testing.

(A) **Definition.** Assessment/Evaluation testing is provided by a clinician utilizing tests selected from currently accepted assessment test batteries. Test results must be reflected in the Service Plan. The medical record must clearly document the need for the testing and what the testing is expected to achieve.

(B) **Qualified practitioners.** Assessment/Evaluation testing will be provided by a psychologist, certified psychometrist, psychological technician of a psychologist, an LBHP or Licensure Candidate. For assessments conducted in a school setting, the Oklahoma State Department of Education (OSDE) requires that a licensed supervisor sign the assessment. Each qualified professional must have a current contract with the ~~Oklahoma Health Care Authority~~ OHCA.

(C) **Documentation requirements.** All psychological services must be ~~reflected by documentation~~ documented in the member's

record. All assessment, testing, and treatment services/units billed must include the following:

- (i) date;
- (ii) start and stop time for each session/unit billed and physical location where service was provided;
- (iii) signature of the provider;
- (iv) credentials of provider;
- (v) specific problem(s), goals and/or objectives addressed;
- (vi) methods used to address problem(s), goals and objectives;
- (vii) progress made toward goals and objectives;
- (viii) patient response to the session or intervention; and
- (ix) any new problem(s), goals and/or objectives identified during the session.

(D) **Service Limitations.** Testing for a child younger than three (3) must be medically necessary and meet established Child (0-36 months of Ageage) criteria as set forth in the ~~Behavioral Health Provider Manual~~ Prior Authorization Manual. Evaluation and testing is clinically appropriate and allowable when an accurate diagnosis and determination of treatment needs is needed. Eight (8) hours/units of testing per patient over the age of three (3), per provider is allowed every ~~12~~twelve (12) months. There may be instances when further testing is appropriate based on established medical necessity criteria found in the ~~Behavioral Health Provider Manual~~ Prior Authorization Manual. Justification for additional testing beyond allowed amount as specified in this section must be clearly explained and documented in the medical record. Testing units must be billed on the date the actual testing, interpretation, scoring, and reporting are performed. A maximum of ~~12~~twelve (12) hours of therapy and testing, per day per rendering provider are allowed. A child who is being treated in an acute inpatient setting can receive separate psychological services by a physician or psychologist as the inpatient per diem is for "non-physician" services only. A child receiving ~~Residential~~residential level treatment in either a therapeutic foster care home, or group home may not receive additional individual, group or family counseling or psychological testing unless allowed by the OHCA or its designated agent. Psychologists employed in State and Federal Agencies, who are not permitted to engage in private practice, cannot be reimbursed for services as an individually contracted provider. For assessment conducted in a school setting the ~~Oklahoma State Department of Education~~OSDE requires that a licensed supervisor sign the assessment. ~~Individuals~~For individuals who qualify for Part

B of Medicare: ~~Payment~~, payment is made utilizing the SoonerCare allowable for comparable services. Payment is made to physicians, LBHPs or psychologists with a license to practice in the state where the services is performed or to practitioners who have completed education requirements and are under current board approved supervision to become licensed.

317:30-5-241.6 Behavioral Health Case Management

Payment is made for behavioral health case management services as set forth in this Section.

(1) **Description of behavioral health case management services.** Services under behavioral health case management are not comparable in amount, duration and scope. The target group for behavioral health case management services are persons under age ~~21~~ twenty-one (21) who are in imminent risk of out-of-home placement for psychiatric or substance abuse reasons or are in out-of-home placement due to psychiatric or substance abuse reasons and chronically and/or severely mentally ill adults who are institutionalized or are at risk of institutionalization. All behavioral health case management services will be subject to medical necessity criteria.

(A) Behavioral health case management services are provided to assist eligible individuals in gaining access to needed medical, social, educational and other services essential to meeting basic human needs. The behavioral health case manager provides assessment of case management needs, development of a case management care plan, referral, linkage, monitoring and advocacy on behalf of the member to gain access to appropriate community resources. The behavioral health case manager must monitor the progress in gaining access to services and continued appropriate utilization of necessary community resources. Behavioral case management is designed to promote recovery, maintain community tenure, and to assist individuals in accessing services for themselves following the case management guidelines established by ODMHSAS. In order to be compensable, the service must be performed utilizing the Strengths Based model of case management. This model of case management assists individuals in identifying and securing the range of resources, both environmental and personal, needed to live in a normally interdependent way in the community. The focus for the helping process is on strengths, interests, abilities, knowledge and capacities of each person, not on their diagnosis, weakness or deficits. The relationship between the service member and the behavioral health case manager is characterized by mutuality, collaboration, and partnership. Assistive activities are designed to occur primarily in the community, but may take

place in the behavioral health case manager's office, if more appropriate. The provider will coordinate with the member and family (if applicable) by phone or face-to-face, to identify immediate needs for return to home/community no more than 72seventy-two (72) hours after notification that the member/family requests case management services. For members discharging from a higher level of care than outpatient, the higher level of care facility is responsible for scheduling an appointment with a case management agency for transition and post discharge services. The case manager will make contact with the member and family (if applicable) for transition from the higher level of care than outpatient back to the community, within 72seventy-two (72) hours of discharge, and then conduct a follow-up appointment/contact within seven days. The case manager will provide linkage/referral to physicians/medication services, psychotherapy services, rehabilitation and/or support services as described in the case management service plan. Case Managers may also provide crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face-to-face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community) to assist member(s) from progression to a higher level of care. During the follow-up phase of these referrals or links, the behavioral health case manager will provide aggressive outreach if appointments or contacts are missed within two business days of the missed appointments. Community/home based case management to assess the needs for services will be scheduled as reflected in the case management service plan, but not less than one time per month. The member/parent/guardian has the right to refuse behavioral health case management and cannot be restricted from other services because of a refusal of behavioral health case management services.

(B) An eligible member/parent/guardian will not be restricted and will have the freedom to choose a behavioral health case management provider as well as providers of other medical care.

(C) In order to ensure that behavioral health case management services appropriately meet the needs of the member and family and are not duplicated, behavioral health case management activities will be provided in accordance with an individualized plan of care.

(D) The individual plan of care must include general goals and objectives pertinent to the overall recovery of the member's (and family, if applicable) needs. Progress notes must relate to the individual plan of care and describe the

specific activities to be performed. The individual plan of care must be developed with participation by, as well as, reviewed and signed by the member, the parent or guardian (if the member is under 18), the behavioral health case manager, and a Licensed Behavioral Health Professional or Licensure Candidate as defined in OAC 317:30-5-240.3(a) and (b).

(E) SoonerCare reimbursable behavioral health case management services include the following:

- (i) Gathering necessary psychological, educational, medical, and social information for the purpose of individual plan of care development.

- (ii) Face-to-face meetings with the member and/or the parent/guardian/family member for the implementation of activities delineated in the individual plan of care.

- (iii) Face-to-face meetings with treatment or service providers, necessary for the implementation of activities delineated in the individual plan of care.

- (iv) Supportive activities such as non-face-to-face communication with the member and/or parent/guardian/family member.

- (v) Non face-to-face communication with treatment or service providers necessary for the implementation of activities delineated in the individual plan of care.

- (vi) Monitoring of the individual plan of care to reassess goals and objectives and assess progress and or barriers to progress.

- (vii) Crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face-to-face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community) to assist member(s) from progression to a higher level of care.

- (viii) Behavioral Health Case Management is available to individuals transitioning from institutions to the community (except individuals ages 22 to 64 who reside in an institution for mental diseases (IMD) or individuals who are inmates of public institutions). Individuals are considered to be transitioning to the community during the last ~~30~~thirty (30) consecutive days of a covered institutional stay. This time is to distinguish case management services that are not within the scope of the institution's discharge planning activities from case management required for transitioning individuals with complex, chronic, medical needs to the community. Transition services provided while the individual is in the institution are to be claimed as delivered on the day of discharge from the institution.

(2) Levels of Case Management.

(A) Resource coordination services are targeted to adults with serious mental illness and children and adolescents with mental illness or serious emotional disturbance, and their families, who need assistance in accessing, coordination, and monitoring of resources and services. Services are provided to assess an individual's strengths and meet needs in order to achieve stability in the community. Standard managers have caseloads of 30 - 35 members. Basic case management/resource coordination is limited to ~~25~~twenty-five (25) units per member per month.

(B) Intensive Case Management (ICM) is targeted to adults with serious and persistent mental illness (including members in PACT programs) and Wraparound Facilitation Case Management (WFCM) is targeted to children with serious mental illness and emotional disorders (including members in a System of Care Network) who are deemed high risk and in need of more intensive CM services. It is designed to ensure access to community agencies, services, and people whose functions are to provide the support, training and assistance required for a stable, safe, and healthy community life, and decreased need for higher levels of care. To produce a high fidelity wraparound process, a facilitator can facilitate between ~~8~~eight (8) and ~~10~~ten (10) families. To ensure that these intense needs are met, case manager caseloads are limited between 10-15 caseloads. The ICM shall be a Certified Behavioral Health Case Manager, have a minimum of ~~2~~two (2) years Behavioral Health Case Management experience, crisis diversion experience, must have attended the ODMHSAS ~~6~~six (6) hours ICM training, and ~~24~~twenty-four (24) hour availability is required. ICM/WFCM is limited to ~~54~~fifty-four (54) units per member per month.

(3) Excluded Services. SoonerCare reimbursable behavioral health case management does not include the following activities:

- (A) physically escorting or transporting a member or family to scheduled appointments or staying with the member during an appointment; ~~or~~
- (B) managing finances; ~~or~~
- (C) providing specific services such as shopping or paying bills; ~~or~~
- (D) ~~Delivering~~delivering bus tickets, food stamps, money, etc.; ~~or~~
- (E) counseling, rehabilitative services, psychiatric assessment, or discharge planning; ~~or~~
- (F) filling out forms, applications, etc., on behalf of the member when the member is not present; ~~or~~
- (G) filling out SoonerCare forms, applications, etc.;

- (H) mentoring or tutoring;
- (I) provision of behavioral health case management services to the same family by two separate behavioral health case management agencies;
- (J) non-face-to-face time spent preparing the assessment document and the service plan paperwork;
- (K) monitoring financial goals;
- (L) services to nursing home residents;
- (M) psychotherapeutic or rehabilitative services, psychiatric assessment, or discharge; or
- (N) services to members residing in ICF/IID facilities.

(4) **Excluded Individuals.** The following SoonerCare members are not eligible for behavioral health case management services:

- (A) children/families for whom behavioral health case management services are available through OKDHS/OJA staff without special arrangements with OKDHS, OJA, and OHCA;
- (B) members receiving Residential Behavior Management Services (RBMS) in a foster care or group home setting unless transitioning into the community;
- (C) residents of ICF/IID and nursing facilities unless transitioning into the community;
- (D) members receiving services under a Home and Community Based services (HCBS) waiver program; or
- (E) members receiving services in the Health Home program.

(5) **Filing Requirements.** Case management services provided to Medicare eligible members should be filed directly with the fiscal agent.

(6) **Documentation requirements.** The service plan must include general goals and objectives pertinent to the overall recovery needs of the member. Progress notes must relate to the service plan and describe the specific activities performed. Behavioral health case management service plan development is compensable time if the time is spent communicating with the member and it must be reviewed and signed by the member, the behavioral health case manager, and a licensed behavioral health professional or licensure candidate as defined at OAC 317:30-5-240.3(a) and (b). All behavioral health case management services rendered must be reflected by documentation in the records. In addition to a complete behavioral health case management service, plan documentation of each session must include but is not limited to:

- (A) date;
- (B) person(s) to whom services are rendered;
- (C) start and stop times for each service;
- (D) original signature or the service provider (original signatures for faxed items must be added to the clinical file within 30 days);

- (E) credentials of the service provider;
- (F) specific service plan needs, goals and/or objectives addressed;
- (G) specific activities performed by the behavioral health case manager on behalf of the child related to advocacy, linkage, referral, or monitoring used to address needs, goals and/or objectives;
- (H) progress and barriers made towards goals, and/or objectives;
- (I) member (family when applicable) response to the service;
- (J) any new service plan needs, goals, and/or objectives identified during the service; and
- (K) member satisfaction with staff intervention.

(7) **Case Management Travel Time.** The rate for case management services assumes that the case manager will spend some amount of time traveling to the member for the face-to-face service. The case manager must only bill for the actual face-to-face time that they spend with the member and not bill for travel time. This would be considered duplicative billing since the rate assumes the travel component already.